



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY IMAGING
8401 DATAPOINT DR STE 600
SAN ANTONIO, TX 78229

Respondent Name

SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-11-3703-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our Physician provided a service to the patient and reimbursement is expected...08/18/2010 Mailed claim for services provided...09/13/2010 Received claim back from insurance stating sent to wrong insurance. "

Amount in Dispute: \$260.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has not submitted satisfactory proof that the initial billing was sent to one of the above entity types. In fact, it appears the health care provider submitted the initial billing to a random company, Spurs Sports & Entertainment, that has absolutely no relation to the insurance industry. Spurs Sports & Entertainment is the parent company of the NBA franchise San Antonio Spurs. Additionally the billing was returned to the health care provider with a note that this is not their employee showing they are not an insurer of any kind nor were they the employer for the injured worker."

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Bldg II, Ste 100, Austin, TX 78735

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| July 31, 2010 | 70450 | \$260.06 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Explanation of benefits dated December 6, 2010
 - 29- Time limit for filing claim/bill has expired
 - RM2- Time limit for filing claim has expired
 - Explanation of benefits dated March 10, 2011
 - 193- Original payment decision maintained
 - RM2- Time limit for filing claim has expired
 - 29-Time Limit for filing claim/bill has expired

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor code §408.0272...a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Requestor states that they originally sent bill to Spurs Sports & Entertainment on August 18, 2010, however, Spurs Sports & Entertainment does not meet the criteria of one of the entity types as described in Texas Labor Code §408.0272. Therefore, Texas Labor Code §408.0272 does not apply to the service in dispute, for that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the documentation submitted by the requestor finds three copies of a medical bill with printed date 08/11/10, 02/01/11 and 06/15/11, a fax transmittal report dated 02/24/2011 and two Explanation of Benefits dated, December 6, 2010 and March 10, 2011. No documentation was found to sufficiently support that a medical bill was submitted to the respondent within 95 days from the date services were provided.
3. In accordance with Texas Labor Code §408.027, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for the service in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

01/23/2012

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.